NHS Connecting for Health

Service Implementation - Do Once and Share

Single Assessment Process Action Team

Final Report

Date: 31/03/06

Author: DOAS SAP Action Team

Project Manager: Dr.R.G.Curry

SHA Lead: Mr. T. Matus

This report consists of 31 pages and 7 appendices which are available separately

Amendment History:

Version	Date	Amendment History
1.0	10/03/06	1st draft, project final report
2.0	20/03/06	2nd draft, project final report
2.1	21/03/06	2nd draft, project final report plus material from SG3
2.2	22/03/06	2nd draft, project final report, recommendations added
2.3	23/03/06	2nd draft, project final report, BAC amendments
2.4	28/03/06	2nd draft, project final report, KS/BAC amendments
2.5	31/03/06	2nd draft, project final report, KS/BAC amendments
3.0	31/03/06	Final Report, sections 3 and 9 added

Forecast Changes:

Anticipated Change	When

Reviewers:

This document must be reviewed by the following. Indicate any delegation for sign off.

Name	Signature	Title / Responsibility	Date	Version
Muir Gray		Director KPS		

Approvals:

This document requires the following approvals:

Name	Signature	Title / Responsibility	Date	Version
Muir Gray		Director KPS		
DOS Programme Manager		Jayne Slater		

Distribution:

<Document text>.

Document Status:

This is a controlled document.

This document version is only valid at the time it is retrieved from controlled filestore, after which a new approved version will replace it.

On receipt of a new issue, please destroy all previous issues (unless a specified earlier issue is baselined for use throughout the programme).

Related Documents:

These documents will provide additional information.

Ref no	Doc Reference Number	Title	Version
1	NPFIT-SHR-QMS-PRP-0015	Glossary of Terms Consolidated.doc	6

Glossary of Terms**:**

List any new terms created in this document. Mail the NPO Quality Manager to have these included in the master glossary above [1].

Term	Acronym	Definition

A selected glossary of terms from the Single Assessment Process and related areas is included as Appendix 7.

For a fuller glossary visit http://www.cpa.org.uk/sap/glossary

Contents

Appendices

1. Overview of the Project

Annex 1.1 Membership of core group
Annex 1.2 Assignment of Deliverables to sub-groups

2. Report from Vision and Pathway sub-group

Annex 2.1 Beginning and Endings
Annex 2.2 Coordination
Annex 2.3 Medicine and Care
Annex 2.4 Specialist Assessments
Annex 2.5 SAP and Two People with Needs
Annex 2.6 Current Summary Record

3. Report from E-SAP Implementation sub-group

Annex 3.1 Project deliverables
Annex 3.2 Sub-group membership
Annex 3.3 Survey questionnaire
Annex 3.4 Localities that responded
Annex 3.5 Conference workshop views
Annex 3.6 Review of E-SAP evaluation reports

4. Report from SAP Community sub-group

Annex 4.1 Membership of the 'SAP Community' subgroup
Annex 4.2 Illustrative CPA Web site statistics 29th Jan - 6th Feb 2006
Annex 4.3 The SAP Community
Annex 4.4 Topics explored on the Discussion Forum
Annex 4.5 Practitioner/Other groups that the SAP resource should be seeking to service
Annex 4.6 Reaching out to the SAP Community
Annex 4.7 Mockups and structure for proposed e-SAP area of the national SAP website
Annex 4.8 Presentation to the Do Once and Share SAP Action Team Conference, 3/2/06
Annex 4.9 Dissemination

5. Report from SAP & Complex Assessments sub-group

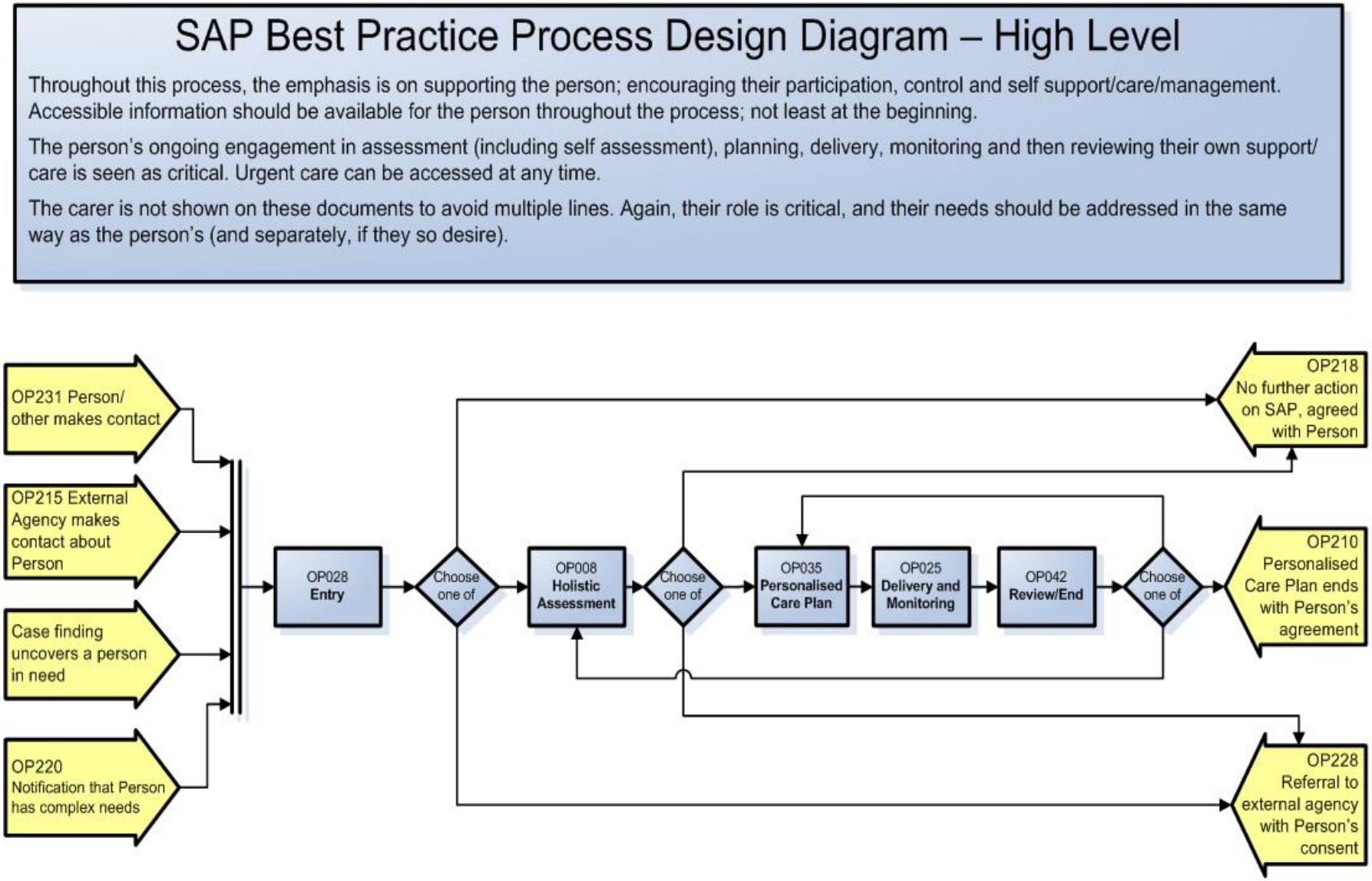
Annex 5.1 Members of sub-group 4 – and involvement in the fieldwork
Annex 5.2 List of deliverables addressed through this work and link to fieldwork template
Annex 5.3 Template for fieldwork
Annex 5.4 Summary of material from DOaS SAP conference 3rd February 2006
Annex 5.5 Working paper – analysis of fieldwork (1) – and list of those involved
Annex 5.6 Working paper – scan of fieldwork (2) – nurse consultants
Annex 5.7 List of additional material collected but not presented in this analysis
Annex 5.8 Additional contacts

6. Report on Project Conference and Workshops

Annex 6.1 Conference programme
Annex 6.2 Conference invitees
Annex 6.3 Final Delegate list
Annex 6.4 Workshop feedback
Annex 6.5 Evaluation form analysis

7. Glossary of Terms

SAP High Level Diagram



ACTION TEAM: Single Assessment Process

ACTION TEAM LEADS: Dr. B.A. Castleton, Mr. K. M. Strahan

PROJECT MANAGER: Dr. R. G. Curry

LOCATION OF ACTION TEAM: Surrey Sussex Strategic Health Authority

SHA LEAD: Mr. T. Matus

ACTION TEAM START DATE: 19th September 2005

DATE OF FINAL REPORT: 31st March 2006

1. BACKGROUND

The Single Assessment Process was first introduced as a concept as part of the NSF for Older People expressly to promote Person Centred Care and also to underpin the other standards in the framework. The purpose of SAP is to "ensure that older people receive appropriate, effective and timely responses to their health and social care needs and resources are used effectively". Ref: NSF Older People and DH Guidelines.

The SAP principles, process, pathway design and practice were the subject of a Best Practice Process Design Group across London and the Southern Cluster, which reported in December 2004. This report sets out in detail how the NSF and Department of Health Guidelines should be put into practice with IT support and the vision for SAP implementation is clearly outlined.

In pursuit of the aim of holistic care, the SAP guidelines stated that:

- "Individuals are placed at the heart of assessment and care planning, and these processes are timely and in proportion to individuals' needs.
- Professionals are willing, able and confident to use their judgement.
- Care plans are routinely produced, engaging individuals and their carers in the planning process and a hard copy given to them.
- Professionals contribute to assessments in the most effective way, and care co-ordinators are assigned in individual cases.
- Information is collected, stored and shared as effectively as possible and subject to consent across relevant agencies.
- Professionals and agencies do not duplicate each other's assessments".

There is a need to coordinate the assessment, care planning and care delivery for people who are developing increasing frailty in old age because they are suffering from multiple long term conditions. SAP is integral to the management of these individuals who need generic comprehensive geriatric assessment and also in-depth specialty assessments.

The complexity of the pathway of delivery is enormous. Thus there is the need to

coordinate the care and ensure timely assessments that are appropriate to the needs of the individual and delivered across agencies.

There is a requirement for the rapid flow of appropriately structured information to the professionals involved and there is a need to generate a summary record and to include a personalised care plan. It is the intention through this mechanism to involve, whenever possible, individuals and carers in managing their own self care/management.

The Current Summary Record already has a draft dataset devised by a group of clinicians working with the NHSIA in 2003 to standardise the format. This is now being reviewed to ensure it is "Spine" compliant. There is also a need to determine how useful this particular dataset is in meeting the needs of those in the field.

There are pilots funded by the Office of the Deputy Prime Minister to look at the Framework for Multi-agency Environments (FAME projects) and two of these projects are dedicated to determining the lessons learnt from rolling-out the Single Assessment Process.

The Care Record Development Board (CRDB) set up an Action Team for SAP to determine the barriers to implementation of IT systems to support SAP. The report of a workshop, held in February 2005, identified thirteen areas for further action. The CRDB Core Action Team for SAP is keen to ensure that the action plan in the report is implemented and wants to work closely with the DOAS SAP Group to take this work forward.

SAP Developments Since the Start of the DOAS Project

In '*A Sure Start to Later Life: Ending Inequalities for Older People': A Social Exclusion Unit Final Report, Chapter 2, P.28 - preventing a cycle of decline and promoting the cycle of well-being*, January 2006, it said, 'the approach that we are advocating brings together key partners of health, social services, benefits and housing, as well as often overlooked missing links such as transport, leisure, community safety and learning. This is about community capacity building to move the debate on from paternalism to prevention and promotion of well-being'.

In January 2006 the *White Paper, Our health, our care, our say: a new direction for community services*; was published. In *Chapter 5, - Support for people with longer-term needs,* it stated that these individuals will be supported by a '**developing Common Assessment Framework for Adults based on the Single Assessment Process'**, with close links to Long Term Conditions, the Care Programme Approach (mental health), Supporting People (housing) and Valuing People (learning disabilities).

The emphasis is on empowering individuals with long-term needs to have more control and support themselves. Better access to information and integrated health and social care plans will be essential.

The White Paper recommends that, "by 2008 it is expected that all PCTs and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs." It states the importance of investment in training and development of skills for staff that care for people with ongoing needs.

In March 2006, *Living well in later life: A review of progress against the National Service Framework for Older People* March 2006 was published - reference is made to the 'Single

Assessment Process' in the chapter on 'Designing and delivering services around older people' - Pages 38-40.

It found that although "The single assessment process is the foundation for building services around individuals,"….."None of the communities that were inspected had introduced one model of single assessment across all partner organisations in the area".

"Four years after the publication of the NSF, the role of strong leadership in 'selling' and promoting the single assessment process at board level and in guiding changes in culture and operational delivery, is more important than ever."

It recommended that, "NHS trusts and social services need to work together to implement the single assessment process fully and to promote its benefits widely in all organisations that are in contact with older people."

Also in March 2006 came the *Wanless Social Care Review, Securing Good Care for Older People: TAKING A LONG-TERM VIEW*. In its conclusion it stated that, "The systems and arrangements required for successful integration according to the evidence are not yet in place, but the policy direction is aligned with their achievement. Case targeting tools, case management, Section 31 flexibilities and the single assessment process are all being developed but are far from being in routine use"…. The Review welcomes the government's agenda to promote further integration. It is promising but there is some way to go."

2. PROJECT OBJECTIVES

- To set up and facilitate a SAP learning and information network.
- To build on work already done nationally within the Best Practice Groups on Single Assessment Process and Long Term Conditions, CRDB SAP Action Team and pilot projects to provide a baseline on the current practice for the implementation of the Single Assessment Process.
- To restate the agreed vision for SAP and any changes envisaged as the service expands over the next five years to 2010.
- To identify from best practice a high level care pathway for SAP that can be agreed as a national standard with localisation areas identified
- To identify from best practice what data is exchanged and between which organisations in the high level care pathway for SAP
- Consider the work done on Case Management Competencies published in August 2005 and determine how Generic Assessment Pathways can link to specialist services covering specific disease processes to integrate the care more effectively for those people with complex multiple disease processes.
- To identify from the vision of SAP over the next five years what data might be exchanged and between which organisations identifying areas of the OBS that need to be adapted and identifying any gaps
- To examine the current methods of linking together all relevant, but currently often discrete, information sources to streamline assessments and care delivery in the interim and look towards the integration of this information in the long term within the NHS Care Record Service and Social Services systems.

3. SHA EXECUTIVE SUMMARY

Name: Mr. T. Matus

The Single Assessment Process is seen as underpinning the delivery of care services to older people and is a key target within the NSF. Integrated working is fundamental to ensuring that this person centred health and social care framework (consisting of entry to service, holistic assessment, personalised care plan delivery of care and review/end) is appropriately delivered to meet the needs of individuals and carers.

All DOAS projects are required to develop care pathways. As SAP is, in fact, a framework for integrated multi-professional working across health and social care which spans condition-specific care pathways, the project focused on developing a 'common national process' for SAP rather than a pathway. This common process is intended to provide a core element of the condition-specific pathways developed by other DOAS projects, in particular, those relating to long-term and complex conditions.

The work of the DOAS SAP project involved consulting with a large number of health and social care professionals from all Clusters on process maps developed in the London & Southern Clusters. This resulted in a draft for a common national Single Assessment Process. The SAP DOAS diagrams will be published on the Centre for Policy on Ageing (CPA) website for a further consultation to the external reference group until the end of April. The complete textual material to go with the diagrams can then be amended.

Also posted on the CPA website is an audit trail in a spreadsheet of the 337 issues identified during the review. Most of the issues have now been resolved through the Cluster representatives on the group. Six Concept/Exploratory papers have also been posted on the CPA website to enable a wider review entitled Beginnings and Endings, Coordination, Medicine and Care, Specialist Assessments, SAP and Two People with Needs, and Current Summary Record http://www.cpa.org.uk/sap

In order to deliver SAP effectively it is essential that clear and efficient processes and pathways are in place within the overarching SAP framework. Where these are achieved, SAP is being implemented with relatively low-technology solutions. However, in order to maximise the potential benefits of the model, a supporting IT infrastructure is essential to enable the timely sharing of appropriate information.

The DOAS SAP Action Team carried out a review of electronic SAP implementations across the country, focusing on those that had made most progress. The review, whilst confirming that progress was being made, both through NHS Connecting for Health and locally implemented systems, identified long-standing issues that continue to reduce benefits and delay progress. Particular issues are the lack of integrated IT systems supporting primary, acute and community based health and social care professionals and lack of mobile devices to enable recording and access to information in the community.

The DOAS SAP project also investigated the triggers into comprehensive assessments as this is widely considered a complex and unclear aspect of the process. We found, however, that there was no consensus on when and what comprised a 'trigger'. Definition of these key triggers would help ensure consistency in process and in outcomes for individuals.

The DOAS SAP project considered how to build a national SAP community to take forward the work from this stage and to share good practice and lessons in the future. The project

recommends the use of the Centre for Policy on Ageing website as a key vehicle for this. The site is used by SAP leads and others involved in implementing SAP and long term conditions care delivery across the country and is now increasingly seen as a valuable resource.

The project has provided survey tools which can be used by the wider community linked into the DOAS SAP Action Team Web Area on the CPA website.

An NHS Connecting for Health initiated project to develop plans for implementing electronic SAP will make use of the work done by the DOAS SAP Action team.

SAP information flows and the evolution of SAP into the proposed Common Assessment Framework need further definition. In order to take this work forward in a coordinated way, clear national leadership is required to bring together a range of stakeholders including the DOAS groups. A DOAS SAP Action Group in collaboration with other DOAS groups could be utilised to enable this work to move forward at speed**.**

The Strategic Health Authority would strongly support the need for a second phase of this work over the next six months to cover these areas, linking with other DOAS projects as appropriate.

Recommendations

1. There is a need to allocate resources to sustain a network to link SAP, Long Term Conditions and other DOaS groups and continue the development of good practice to inform NHS Connecting for Health.

2. The Centre for Policy on Ageing website must be resourced to continue to provide a vehicle for collaborating on a national basis on the evolution of SAP and sharing of good practice.

3. Information collected by the DOAS SAP Action Team should feed into the work being undertaken by the Personal Social Services Research Unit (PSSRU) on the implementation of SAP in England.

4. A model of working for SAP must be agreed by all parties – clinicians, individuals, carers, IT experts – that:
    - defines what information should flow, when and to whom and ensures that flows go across health **and** social care
    - gauges the usefulness of the Current Summary Record
    - makes clear the role of the “Spine”.
    - shows how complex assessments are triggered
    - identifies good practice in SAP which can be used to build into the proposed Common Assessment Framework for adults and identifies evolution paths.

5. Development of this working model should be supported and resourced by NHS Connecting for Health.

6. Clear, unambiguous guidance (which is mindful of, and exploits, modern IT systems) from the Department of Health on the implementation of informed consent is required as soon as possible.

7. There should be a properly resourced, joint training plan for each locality, with a combined Competency Framework, based on the work in Long Term Conditions.

8. A Second Phase of the SAP DOaS project is required to take forward these recommendations and to link to the development of the proposed Common Assessment Framework for Adults and Personalised Care Plans as outlined in the White Paper 'Our health, our care, our say: a new direction for community services'.

(Please also see - 9. Clinical and Social Care Leads Comments and Conclusions)

4. DETAILED REPORT ON WORK WITHIN SCOPE (any outputs from this work which are not covered as specific deliverables)

Output 1: ***SAP and Long Term Conditions (LTC) - Making links with other DOaS groups, Department of Health and other policy groups***

Status: Complete.
Date of Completion: 31st March 2006.

Summary:
The Centre for Policy on Ageing SAP website and resource is being used to disseminate SAP DOaS findings both to other DOaS groups and more widely. The resource and NHS Care Record Glossary incorporate links to Long Term Conditions (also on LTC national website).

- Initial contact was made with associated DOaS groups, notably complex conditions, falls, cancer, children's mental health services, learning disability, heart failure, diabetes.
- Contact has been made on datasets with staff from the Information Centre.
- Keith Strahan communicated with DOAS project leads David Lyon (Complex Conditions in Later Life) and Dee Harrington (Care Pathway).
- Richard Allen communicated with Learning Disabilities lead Jacqui Howard.
- Beverly Castleton was in discussion with Sue Roberts to link the work of the DOAS Diabetes group with that of DOAS SAP.
- Keith Strahan attended 'In-Control' Individual Budgets conference on the 9.3.06.
- Long Term Conditions – Keith Strahan met with LTC national leads at Richmond House on the 22.12.05.
- Keith Strahan attended DH White Paper meeting on the 3.12.05.
- Ian Swanson communicated with colleagues in ADSS.
- All linked to work led by Seamus Bream, Sara Bird and Matthew Fagg at the Department of Health (DH).
- Each of the cluster representatives had contact back with cluster groups on SAP.

Relevant Appendices: 2, 3, 4, 5

Output 2: ***Survey Instruments***

Status: Complete.
Date of Completion: 31st March 2006.

Summary:
During the course of the work two survey instruments were developed

- a questionnaire to examine the implementation of electronic versions of SAP
- a template/questionnaire to examine the use of complex/comprehensive assessments within the Single Assessment Process.

Both instruments can be found in the Do Once and Share area of the Centre for Policy on Ageing SAP on-line resource and in Annexes 3.3 and 5.3 respectively of this report.

Relevant Appendices: 3, 4, 5

Output 3: ***Triggering between SAP and Complex Assessments***

Status: Complete.
Date of Completion: 31st March 2006.

Summary:
Triggers are not usually explicit or defined but part of emergent local working arrangements between teams.

There is currently no common understanding of 'comprehensive assessment' or agreement about what triggers are in place or need to be in place to enable movement into either comprehensive or complex assessment.

The role of IT in this area was not clear.

Relevant Appendix: 5

Output 4: ***Consent***

Status: Complete.
Date of Completion: 31st March 2006.

Summary:
In the current situation, consent to share across the NHS and social care needs to be explicitly gathered at regular intervals, and we may need to trust consent gathering procedures across boundaries.

Relevant Appendix: 3

Output 5: ***Conferences and Workshops***

Status: Complete.
Date of Completion: 31st March 2006

Summary:
During the course of the project two national conference workshops were held to discuss the findings, to gain consensus and to identify a National SAP reference group.

The conference findings were disseminated through the Centre for Policy on Ageing SAP website and resource.

Relevant Appendices: 2, 4, 6

5. UPDATE ON PROJECT CONSTRAINTS and RISKS

Data collection and analysis time was constrained by the short duration of the project. Whilst every effort was made to obtain a representative sample to study, there may be some unintentional bias. For this reason the findings and conclusions should be treated as indicative.

During the course of the project in January 2006, two important documents with direct relevance to SAP were published and two further major reports were published in March 2006 (see note added to section 1. Background). The recommendations of this report are in line with these documents but indicate that there is much more work to be undertaken.

6. DETAILS OF ANY CONTINGENCIES IMPLEMENTED

Additional project support was required because of time pressures on various members of the team and was utilised to support sub groups 2 and 4 to enable delivery within the timescale.

7. DELIVERABLES (progress report on all deliverables listed in the Scoping Document)

7.1) <u>Deliverable name:</u>
Restate the vision for SAP which will continue to evolve

Status: Complete.
Work of SG1 and SG4
Date for completion: 31st March 2006.

Summary:
The Single Assessment Process (SAP) was first mentioned in Standard 2: Person Centred Care in the NSF for Older People. Then came the SAP guidelines in January 2002,

"The DH stages of the single assessment process are:

- Publishing information about services
- Case finding (optional)
- Completing assessment – the four types, Contact, Overview, Specialist and Comprehensive.
- Evaluating assessment information
- Deciding what help should be offered, including eligibility decisions
- Care planning (leading to service delivery)
- Monitoring and review"

There have been times over the past 4 years when SAP has been viewed incorrectly as only an assessment tool, or 4 types of assessment, or an electronic system.

However, as we have seen from the original guidance, the Single Assessment Process always was supposed to be a person centred, health and social care framework including:- Entry into Service, Holistic Assessment, Care Planning, Care Delivery and Review (as outlined by the London/South Best Practice work and confirmed by the SAP DOAS work).

SAP was timetabled to be fully implemented by April 2004. Although progress was made

this did not happen and impetus started to fade in many areas.

SAP has tended to be a 'bottom up' approach, with the commitment of staff within health and social care (in the widest sense) in localities the greatest positive factor driving the integrated working agenda.

SAP is already being used for other adult groups as well as older people in many localities. It links, complements and is enhanced by other key areas of policy, such as Long term Conditions, with its emphasis on supported self care / self management, personalised care plans and using case management to provide care for individuals with complex needs.

Whilst there is awareness of the SAP Vision in the field there is some confusion between the terms 'complex' and comprehensive assessments and much locally based interpretation.

Practically all those who responded used SAP for contact and overview assessments, most used SAP for referral and some did specialist and/or comprehensive assessments – with the suggestion that in due course, comprehensive, and when appropriate, specialist assessments would become the 'norm'.

The three possible models showed how a comprehensive assessment can be built up (please see Appendix 5).

A phased approach could be appropriate for a transition from paper-based systems to 'electronic' – tailored to the different starting points and end points envisaged in the models.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 2,5,6

7.2) Deliverable name:
Provide examples of good current implementation of SAP assessment processes and share across the network

Status: Complete.
Work of SG2 and SG3
Date for completion: 31st March 2006.

Summary:
The work of sub-group 2, covered 15 electronic SAP implementations (2 to 3 in each Cluster), which were identified by Cluster SAP leads as having made substantial progress. Although limited in scale, the survey provided opportunities for identifying learning from implementations of electronic support for the single assessment process in particular in terms of, the extent of implementation across health and social care communities, use of systems beyond people aged 65 and over and the type of functionality in use, integration

methods used and which systems were integrated, use of mobile devices, common barriers and issues, benefits and success factors. There were also opportunities to begin to share that learning, initially through the conference workshop and subsequently through the Centre for Policy on Ageing SAP website.

The issues which had been identified by the CRDB SAP Action Team previously were re-emphasised in this study, i.e. that the lack of integration between health and social care systems and of mobile devices reduced the benefits of SAP as care professionals had to duplicate information recording.

The Centre for Policy on Ageing SAP website and resource is specifically designed to share experiences and propagate SAP good practice, including e-SAP. The site provides examples of successful SAP implementations and of problems encountered.

Stakeholder Consultation process: Conference and workshops on 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 3, 4

7.3) Deliverable name:
Create an engaged and informed SAP community of interest to aid the further development of SAP

Status: Complete.
Work of SG3
Date for completion: 31st March 2006.

Summary:
A wide and diverse SAP community was reached through the establishment of the CPA website and resource. Through involving the community with the development of the resource at all stages the community has remained engaged with SAP.

SAP materials, websites, links to other related initiatives and the NHS Care Record Service Glossary of Health, Social Care and IT have ensured continued engagement of the community.

The SAP resource makes connection between joint working of different agencies; crossing professional and physical boundaries to aid the future development of SAP.

Promotion of best practice and avoiding duplication of effort by sharing the learning, via the resource, has helped create a more positive culture within the SAP community and therefore has helped to reinvigorate SAP.

The SAP resource will now include information about the implementation of 'e-SAP' and 'SAP and long term conditions' to keep the SAP community engaged and informed to aid future SAP development and the emerging Common Assessment Framework.

The SAP discussion forum will be geared to engage more 'front line' workers and to reach

a wider audience, including particular groups of practitioners such as GPs, OTs and Mental Health teams.

PSSRU evaluation of SAP is, as yet, not complete and not available. Any illustrative practice emanating from the study can be shared with the SAP community via the resource.

Discussions are on-going to promote and make visible the SAP resource on the National Electronic Library of Health (NeLH).

Stakeholder consultation process: National Capita conference 31 Jan 06; National DOAS conference and workshops 3 Feb 06

Evidence of national stakeholder sign off / agreement: conference feedback; discussion forum feedback; resource feedback

Issues: none.

Mitigations: none.

Relevant Appendix: 4

7.4) Deliverable name:
Describe a high level care pathway for SAP that can be agreed as a national standard with localisation areas identified

Status: Complete.
Work of SG1
Date for completion: 31st March 2006.

Summary:
The group discovered that just "assessment" is not enough to support the SAP pathway of care: SAP needs to deal with the complete support/care process for individuals.

SG1 highlighted 5 main 'areas': entry into service, holistic assessment, personalised care plan, care delivery and monitoring and review/end.

Communication should be centred on the individual, based on holistic assessment and the individual's integrated heath and social care personalised care plan (emphasised strongly in the Joint Health and Social Care White Paper in January 2006). This is critical to support the individual and their carer(s) in their own self care and self management, leading to more dignity and control.

There is widespread agreement that a high level process is necessary, and there is even a fair amount of agreement at the level documented.

There is probably only one basic person centred process for the support of people with complex needs, and any key differences in that process will depend on whether the individual has sole responsibility for co-ordination and management or whether this responsibility is shared / supported by professionals.

The pathway is used separately or jointly in both health and social services and most of the work can be done by either service. The pathway could also transfer from one service to another depending on the focus of care. The pathway works at a high level, and there is

even a fair amount of agreement at the level documented.

Person centred care across agencies requires person centred records across agencies, and there will probably be records held on at least two systems – health systems and local government systems. (There may be third systems in the short term that transfer information into both health and social services systems). There may also be a need to link with other agency systems, e.g. voluntary and independent sector.

In an increasingly electronic age, with an increasing variety of care and support organisations, this material will need to be transferred between systems, and communicated electronically with the person and we will need standards to enable this.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 2, 6

7.5) Deliverable name:
Identify current information flows between organisations

Status: Complete.
Work of SG1, SG2 and SG4
Date for completion: 31st March 2006.

Summary:
Currently there is no consensus on what information needs to flow between statutory organisations and for what purpose.

SAP and other related information tends not to flow between the statutory and independent sectors.

The link between disease registers and other related data islands and SAP was not explicit.

Most of the barriers and problems identified in relation to the implementation of electronic support for the single assessment process have been identified previously - notably in the North West Electronic Government IM&T Baseline Review of Single Assessment, July 2003 (see CPA website) and the CRDB SAP Action Team Output (March 2005) - and it appears that most still apply to varying degrees. What is apparent is that, just as information sharing was constrained previously by paper systems, so information sharing is still limited with interim electronic solutions essentially because they are not fully integrated.

This is compounded by the lack of clarity about timescales, social care interfaces, support for assessment tools and migration plans with LSP strategic solutions.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 2,3,5

7.6) Deliverable name:
Describe a vision for SAP

Status: Complete.
Work of SG1 and SG4
Date for completion: 31st March 2006.

Summary:
From the White Paper, Our health, our care, our say: a new direction for community services, Chapter 5, - Support for people with longer-term needs, January 2006,

"We have already developed a Single Assessment Process for older people's services. Work is underway to build on this to develop a Common Assessment Framework for Adults to ensure less duplication across different agencies and allow people to self assess where possible."

"An integrated health and social care information system for shared care is planned as part of the NHS Connecting for Health strategy. It is an essential requirement for effective care co-ordination."

"An integrated health and social care information system will enable a shared health and social care plan to follow a person as they move through the care system"
(**Note**: this should show the underlying commitment to engaging individuals and their carers in their own support/care and the choices around it).

"We will ensure that, ultimately, everyone who requires and wants one has a personal health and social care plan as part of an integrated health and social care record. Initially we will focus on offering integrated care plans to those individuals who have complex health and social care needs."

"By 2008 we would expect everyone with both long-term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long-term condition to be offered a care plan. We will issue good practice guidance early in 2007."

It is worth noting the influence that Long Term Conditions and Case Management (with its emphasis on self care/self management) has had in health and, in social care, it is likely that the ethos of self directed support and the growth of resource allocation to people through individual budgets will have great significance over the next few years (from 'care' to 'support'?).

Consultation process and stakeholder agreement: National DOAS conferences on 13th December 2005 and 3rd February 2006.

Issues: none.

Mitigations: none.

Relevant appendices: 2,5,6

7.7) Deliverable name:
I***dentify likely information flows between organisations and identify gaps in the current OBS***

Status: Complete.
Work of SG1 and SG2
Date for completion: 31st March 2006.

Summary:
Share main items (for definition see the concept paper on the **Current Summary Record, Annex 6, Appendix 2**) for which there is a need for agreed naming conventions and minimum data fields.

The personalised integrated care plan is at the centre of sharing, alongside common demographic materials, (including other interested parties, and the home environment) and allocations of staff/teams (to show and contact those involved in care).

There is a need to share any assessment in terms of event details and its conclusions, preferably with access to the whole assessment when more information is required.

There is the need for a medical summary highlighting current conditions and their treatment, and any major matters of history.

Where a professional records in a system outside their normal business system (assumed to be a separate health or social services system), management information needs to be transferred as well (but management information out of context may not be sufficiently meaningful).

In terms of sharing, the transfer of forms/documents would be of value to the transfer of information, especially if any data items took a long time to define and reconcile.

With SAP there needs to be sharing across the social care community which is much wider than health and social services – maybe done on paper and fax to start with, re-using forms in the system (edited for consent issues).

Enabling staff to communicate electronically (secure e-mail) would be immensely supportive of the process until systems became clearer.

Within care/support elements of holding information, we should concentrate on sharing material around lifestyle in the person's own terms to ensure a full description rather than reducing things to a code, especially since this material should always be communicated back to the individual. This could be coded afterwards for management/research purposes.

It must be remembered that our assessment and support/care material should be routinely shared in a meaningful way with the individual.

The whole record needs to build up over an individual’s life, but there will be periods (possibly ongoing and indefinite until death) when health and social care must take a

holistic overview of needs and support/care alongside the individual. At the beginning of such periods material needs to be collated from currently recorded health and social care information. From a health point of view, this is probably a summary of the GP record – detailing current problems and treatments, and major items of history (subject to consent).

Similarly needs generated and summarised within a specialist assessment should be collated together into any holistic assessment (like the SAP overview), and drive the care plan. This assumes consent has been sought and given to move and share the individual's information in this way.

Have methods of ending multi agency and holistic care when appropriate to do so.

During multi agency and holistic care make a nominated worker/team and a review process mandatory in systems.

Make the review process consider outcomes in terms of the predictions in the care plan, and analyse outcomes in terms of the person's realistic expectations of their support/care. Including analysing outcomes in case of death or other exit.

There are two levels of care planning – a holistic level, done in great collaboration with the individual that may prioritise interventions and fit them with an individual's needs and lifestyle, and a service specific level which will provide detailed (and sometimes technical information) methods of carrying out care as guidance for care workers.

All sharing across agencies is subject to consent and material may need to be edited before being shared outside an organisation/service (health or social services).

Mandate the sharing of information when there are triggers to complex needs unless the person has expressly dissented, and make express consent / dissent mandatory on the major stages in the process.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms.

Issues: none.

Mitigations: none.

Relevant Appendices: 2,3

7.8) Deliverable name:
Review current use of datasets for SAP, such as the Current Summary Record and consider its usefulness in field

Status: Complete.
Work of SG1, SG2 and SG4
Date for completion: 31st March 2006.

Summary:
There is limited use of a common dataset. Some locally defined common datasets were found.

The Current Summary Record - SAP (CSR) is not frequently used unless it is available in electronic form.

There are doubts about the coding of the support/care elements of the current dataset for information sharing purposes. A link between the SAP dataset and other datasets was not explicit.

We need to move from sharing something created artificially, the Current Summary Record, with no clear timing to share (and therefore potentially lacking currency) to sharing items naturally created as they happen, and especially the items (like the personalised care plan), which are shared with the individual (and might typically be found in their person-held record).

These items typically made up the Current Summary Record, but were reduced in it to limited codes in the NHSIA dataset.

Within these items, there is the need for a medical summary highlighting current conditions and their treatment, and any major matters of history.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Appendices: 2,3.5

7.9) Deliverable name:
Consider tactical interim solutions and an integrated approach across health and social care for determining future IT

Status: Complete.
Work of SG1 and SG2
Date for completion: 31st March 2006.

Summary findings:
Most of the barriers and problems identified through the survey and the conference workshop have been identified previously - notably in the North West Electronic Government IM&T Baseline Review of Single Assessment (July 2003) and the CRDB SAP Action Team Output (March 2005) and it appears that most still apply to varying degrees.

What is apparent is that, just as information sharing was constrained previously by paper systems, so information sharing is still limited with interim electronic solutions essentially because they are not fully integrated.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 2 & 3

7.10) Deliverable name:
Identification of training needs

Status: Complete.
Work of SG1, SG2, SG3 and SG4
Date for completion: 31st March 2006.

Summary:
Direct training is essential. Cascading is not effective.

Basic IT skills cannot be assumed.

Training on a multidisciplinary basis with handholding in the early stages has proved successful.

There are still differences across health and social care, especially in terms of vocabularies, joint working attitudes and cultures.

The question as to who can undertake coordination should be examined in the light of the recent White Paper's recommendation that, "by 2008 it is expected that all PCTs and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs.

Good, well-resourced awareness raising and associated joint training is critical to implementing SAP in general and electronic SAP in particular.

Some localities have overcome issues that others are still describing as barriers, such as with Executive level buy in and specialist practitioners using SAP as their core process. There would clearly be benefit in learning more about how some localities have managed to overcome these barriers. Effective training was a common success factor.

Stakeholder Consultation process: Conferences and workshops on 13/12/05 and 3/2/06

Evidence of national stakeholder agreement: Conference and workshop feedback forms

Issues: none.

Mitigations: none.

Relevant Appendices: 2,3,5

7.11) Deliverable name:
Consider areas currently out of scope for further work streams

Status: Complete.
Work of core group post conference
Date for completion: 31st March 2006.

Summary:
SAP offers the opportunity for generic assessments to be undertaken as a basis for referral either for specialist assessments or for LTC type assessments.

There are signs that SAP momentum is building up – Community Matrons and pilot initiatives are assisting this.

The analysis of the fieldwork was not completed and may contain additional material of 'value'.

The unresolved questions identified at the conference should be addressed.

Additional fieldwork with tool user groups could be timely.

The work of the project has only scratched the surface of the learning that could be identified from implementations of electronic SAP solutions. For example, a comprehensive identification of implemented interim solutions would be beneficial and feasible and it is likely the NHS Connecting for Health project, 'A National Framework For Electronic SAP Implementation' will cover this and complement any future SAP DOAS work. Also, finding out more detail about change management processes involved in successful implementations would have benefits for related future development and implementation of strategic solutions.

As SAP is a shared process, with joint working, there must be joint electronic methods of sharing information through linking systems effectively.

Proposed Stakeholder Consultation process: Further conferences and workshops with a wider audience. Increased use of CPA SAP resource website as a means of communicating with the SAP community and obtaining information from the community.

Evidence of national stakeholder sign off / agreement: n/a

Issues: none.

Mitigations: none.

Relevant Appendices: 2,3,4,5

8. RECOMMENDATIONS FOLLOWING FROM OUTPUTS AND DELIVERABLES

Output 1:
SAP and Long Term Conditions. Links with other DOaS groups

One of the key outcomes of this piece of work is the emergence of a network within the SAP community and with links into other care and policy development communities. It is very important that this network is sustained and developed.

Output 2:
Survey Instruments

The survey instruments should be developed further and used in conjunction with the CPA SAP resource to collect information on SAP implementations and links between SAP and other assessments.

Output 3:
Triggering between SAP and Complex Assessments

There is a need to be clear how SAP will work (including the nature of 'triggers'), which all parties (clinicians, users, carers, etc) need to agree.

Models of working need to be devised and clear definitions of assessments and other terms are needed (e.g. comprehensive, complex, specialist – generic and focussed etc) which show their inter-relationships. Such models need to be integrated with other associated i.e. Long Term Conditions.

The models developed - and the 'triggers' in particular need to be tested to confirm 'fitness for purpose', impact on the individuals journey along appropriate pathways and implications for joint care delivery.

The models developed need to be clearer about the role of IT.

Output 4:
Consent

Clear unambiguous guidance from the centre on the implementation of informed consent (including recording), whether in relation to electronic or paper records, is required at the earliest opportunity.

Deliverables 1 & 6:
Restate vision for SAP & Describe a vision for SAP

Revise in line with the White Paper. To provide a foundation for a Common Assessment Framework for Adults, encouraging greater consensus about the definitions of SAP assessments and how they relate to care processes and the care pathway. Ongoing group needed.

Have a team working with the White Paper implementation team that handles and costs the information technology issues at the same time as the White Paper is turned into policy or legislation. Recommendation to the DH from CfH.

Continue to link with other DOAS projects to take forward the work, including the concept of SAP as a core/ generic part of all care pathways and link to the White Paper. A focus of the work should be the development of personalised integrated care plans facilitated by NHS Connecting for Health. Recommendation to be distributed to all adult DOAS projects.

Ensure that any implementation plans cross health and social care. Recommendation to DH from CfH.

Deliverable 2:
Provide examples of good current implementation of SAP assessment processes and share across the network

A more comprehensive identification of implemented interim solutions should be undertaken within the CfH electronic SAP project on models for integration.

Investigate change management processes used in successful implementation through on-site visits/interviews and cluster level focus groups and feed into future development and implementation of strategic solutions.

LSPs should be required to provide clarity about: timescales for implementation of functionality which will support SAP/Common Assessment Framework; about support for assessment tools; their approach to interfacing with social services systems; plans for migration from interim solutions.

Deliverable 3:
Create an engaged and informed SAP community of interest to aid the further development of SAP

The outputs of relevant cluster level Expert Reference Groups, or their equivalent to be identified by the Centre for Policy on Ageing and shared through the SAP website.

Centre for Policy on Ageing national SAP website and resource has developed and fostered a community of interest. The resource therefore needs to be appropriately funded to ensure this work is sustained to support the emerging future development of SAP and to create the right environment, through shared learning and practice, to engender the benefits of integrated working.

Resource provision should allow for the extension and expansion of the website and resource to encompass e-SAP, long term conditions and the provision for special interest groups outlined above.

The resource to continue to connect with and identify other related initiatives, websites and materials to ensure a more comprehensive understanding of the vision as outlined in the White Paper and, therefore ensure better and extended community 'buy-in' of SAP and emerging Common Assessment Framework.

The resource to build on its networks to ensure continued communication with all stakeholder groups including service users and carers – who both use the resource.

To ensure that all elements of the SAP website and resource are made visible on the National Electronic Library for Health (NeLH).

Raise awareness of all aspects of the SAP website and resource with clinical reference and best practice groups established through CfH to support their activities.

The resource to continue to support shared learning and practice to avoid duplication of effort and to address cultural change needed for successful integrated working.

The resource to continue to help with promotion of the SAP vision in a clear and accessible way to the SAP community.

Feedback from the SAP community, which comes via the resource, to be properly linked into other initiatives and other DOAS teams through appropriate advisory or other reference groups – thereby ensuring positive engagement of the stakeholder community.

Deliverable 4:
Describe a high level care pathway for SAP that can be agreed as a national standard with localisation areas identified

The SAP DOAS diagrams will be finalised by the end of May in the light of a further consultation after publication to the external reference group via the CPA web site. The textual material to go with the diagrams will then be completed.

Create and maintain a continuing inter-agency sub-group to maintain the process and make decisions on variation, given the need for standards across the country.

Ensure that any subsequent system work contains sufficient flexibility (since SAP is relatively new) to fully support the process of ongoing development .

Embody the main elements of the pathway in standards to be defined nationally, to enable systems to work in approximately the same way for those main elements. Needs governance and standards work – CRS and ESCR boards.

Deliverable 5:
Identify current information flows between organisations

Given the white paper and mixed economy emerging consider opportunities for improvements in information flow (including use of regulatory and other levers) – and encourage CFH to ensure that mechanisms and associated infrastructure are in place to enable that flow to happen.

Get consensus on what the information flow needs are - including those for personalised care plans.

Clarify what the Spine will and won't do to support SAP processes. Confirm when the Spine will be available in support of SAP (If this is more than 2 years, then there must be interim solutions to enable the information flows required for SAP and common assessment).

Clarify the link between Disease Registers and other related 'data' islands and SAP.

Ensure that the Comprehensive Assessment explicitly includes Medical Assessment.

A need for Clear unambiguous guidance from the centre on the implementation of informed consent (including recording), whether in relation to electronic or paper records, is required at the earliest opportunity.

Make sure all the SAP DOAS project outcomes are shared with the NHS Connecting for Health project, 'A National Framework For Electronic SAP Implementation'.

Deliverable 7:
Identify likely information flows between organisations and identify gaps in the current OBS

Create an approach based on standards to allow for the variety in the health and social care IT market, and the interconnectivity of many different organisations.

Ensure that workers can communicate electronically and securely through e-mail in advance of and alongside systems. Identify a national owner for secure e-mail.

Having built agreement on the sharing of documents, consider a domain based method as a way of building up material from different systems, starting the process towards greater integration (see concept paper: Beginnings and Endings). Recommendation to consult LSPs and Social Services suppliers about this concept.

Experiment with methods of engaging individuals in their own care, and research the

effects. Consult individuals about the principles in this work. Further work.

Consider the principles underlying 'HealthSpace' and use of the national data 'Spine' in the light of differences between medical and care information (please see concept paper: Medicine and Care). Ensure care information does not stigmatise the individual. HealthSpace to address how it expects to store care information in the light of this material.

In the current situation, consent to share across the NHS and social care needs to be explicitly gathered at regular intervals, and we may need to trust consent gathering procedures across boundaries.

Consider how common information governance principles can be built into the various health and social services systems. CRS and ESCR boards to develop, approve and mandate common standards. Care Record Guarantee to be reviewed in the light of the White Paper

Deliverable 8:
Review current use of datasets for SAP such as the CSR and consider its usefulness in the field

The current limited use of the CSR (SAP dataset) in the field means that this needs to be re-visited to identify its fitness for future purpose.

A link between SAP datasets, findings from other associated DOaS groups, proposals for common assessment arising from the white paper and proposals for the CSR for the Spine and associated messaging needs to be made.

Move from the concept of a current summary record to the sharing of the following items between systems, as they happen or as they are compiled, and define the content (which may be free text in some circumstances):

- **Medical summary**
- **Basic Personal information**
- **Event details of all assessments and their conclusions (and potentially access to them)**
- **Allocated professional/care team details**
- **Integrated Care Plan**
- **Referrals**
- **Informed Consent**

Deliverable 9:
Consider tactical interim solutions and an integrated approach across health and social care for determining future IT

If interim solutions are implemented they must be integrated across health and social care and there must be clarity about timescales, social care interfaces, support for assessment tools and migration plans with LSP strategic solutions.

Deliverable 10:
Identification of training needs

There is a necessity for clarification about Care Management/Case Management roles in light of the White paper.

There should be a combined Competency Framework (with the acknowledgement of each disciplines specialist area) maybe using as a basis the Case Management Competencies for Long Term Conditions (linking with Skills for Health and Skills for Care).

There must be a properly resourced joint training plan in each 'locality'.

The requirement for a responsible professional/named contact (not necessarily a qualified worker) to support individuals with their lower level needs will also need definition.

A shift to 'signposting on' in health and social care rather than 'screening out' is essential not least, when eligibility decisions are made.

Examine how IT enables an individual to take control of their own life; including coordinating and managing their own health and social care support. This has implications for HealthSpace. What access will individuals have to their electronic 'case' file in the future– not least their integrated care plan?

Continue to address cultural change towards greater joint working.

Deliverable 11:
Areas for further work

It is recommended that further work be undertaken on how health and social care professionals can be further enabled to facilitate more integrated team working to implement the proposed Common Assessment Framework as flagged in the White Paper. This work will need to include people with multiple complex conditions in all care settings, including Care Homes and Care Homes with Nursing.

SAP, and the emerging Common Assessment Framework, should be viewed as core integrated functionality (for referral, assessment, care planning, review etc) within strategic health and social care systems rather than being seen as a separate SAP or Common Assessment Framework.

Key messages from the first phase of SAP DOaS should be fed into the development of the Common Assessment Framework for Adults. In the Clinical and Social Care Leads Comments and Conclusions below we discuss how this could be taken forward.

9. Clinical and Social Care Leads Comments and Conclusions

The implementation of the Single Assessment Process was always perceived as an evolving iterative process. Implementation is happening at different rates in different locations across England.

Most progress has been made with health and social care agencies in the community (less so with GP practices), with only limited involvement from the acute sector. There are few communities that have introduced one model of single assessment across all partner organisations in their area. The lack of a shared electronic system for keeping records is a

major barrier and there are still difficulties and disagreements about what information could be shared between partners.

The requirement remains for SAP (with Long Term Conditions closely aligned) to provide the generic health and social care framework. It is the basis for the proposed Common Assessment Framework for Adults and should be seen in a context of whole system delivery. The emphasis is on supporting people to have more choice and control through the delivery of person centred, holistic care in the community and utilising hospitals when essential and relevant.

There are many areas of SAP good practice, which have been detailed in the Appendices and this work needs to be more widely shared and implementation consolidated. This requirement was clearly outlined in the report published in March 2006 - Living Well in Later Life - reviewing progress against the NSF for Older People. It was stated that "Joint indicators will be developed to support improvement in key areas" and one of these was "the full implementation of the single assessment process across health and local authority partners".

The DOAS SAP Action Team has enabled a vibrant learning environment to be set up utilising the Centre for Policy on Ageing website where systems of assessment and the information flows required can be refined and developed through the network created. Already the Centre for Policy on Ageing's NHS Care Record Service SAP Health and Social Care Glossary can be seen on the Long Term Conditions national website.

The need for integrated teamwork across primary and secondary care and across Social Care and the wider community is essential. There are several areas we would want to explore in the next phase of the work if we were successful in securing funding. These would include working with other DOAS groups, such as Diabetes, Complex End of Life Issues and Learning Disabilities. All the leads of these groups are supportive of this approach and we would be in a position to detail the scope of the next phase as soon as required to do so.

10. DOaS Programme Comments

[Type comments here]

SIGN OFF

SHA Lead	
Name:	T. Matus
Signature:	
Date:	
DOAS Programme Manager	
Name:	Jayne Slater
Signature:	
Date:	
KPS Programme Director:	
Name:	Muir Gray
Signature:	
Date:	